Washington State Department of Social & Health Services

System Transformation Initiative

Presentation for the Washington State House Committee on Health Care & Wellness

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Richard E. Kellogg
Department of Social and Health Services
Health and Recovery Services Administration
Mental Health Division - Director

STI Studies

Long Term Planning Studies

- Benefits Package/ Rates- TRI West
- Involuntary Treatment Act- TRI West/ Advocates for Human Potential
- Mental Health Housing Plan- Common Ground
- External Utilization Review- University of Washington- Harborview

STI Implementation

Process

- Consultants For Each Project Initiative through RFPs
- Standing Representative Task Force
  - 35-40 members from variety of interested parties
  - Monthly meetings beginning in Oct 06
- Community Forums- approximately 150 people each
  - November 06, January 07, May 07, and July 07
- Tribal Roundtable and focus groups- Feb - May 2007
- Focus Groups- by consultants as needed
- STI Web Site
- Product- Reports with consultant recommendations to DSHS/MHD for improvements
- MHD prioritization of recommendations for further development

Benefits Package Update

Benefits Package- Access To Care

Report Findings

To receive Medicaid services through an RSN, a person must:

- Have a covered diagnosis (there are two lists- List A & List B)
- Have a functional impairment measured by a standard functioning protocol (GAF for adults, CGAS for children/adolescents)
- If B diagnosis, have additional risk issues

Challenges

- Functional impairment requirements provide a barrier to early intervention for high-risk populations
- Dilutes emphasis on managing higher need cases (long-term case management, day support, residential services)

Benefits Package- Access To Care

Report Recommendations Prioritized by MHD for Further Development

- Conduct actuarial analysis of the financial impact of revising GAF and CGAS minimums for routine outpatient care
- If financially feasible, raise the GAF and CGAS minimums to at least 70 for all covered diagnoses
- Develop statewide standards for continuing care and discharge in order to shift focus from front-end restrictions for all enrollees to proactive care management of services for enrollees with intensive, ongoing needs
  - Statewide medical necessity standards for all levels of care
  - Include criteria for initial and ongoing reviews

Benefits Package- Services

Report Findings

- Analysis of Washington's State Medicaid Plan compared to AZ, CO, NM and PA
  - WA's State Plan is very flexible; able to promote wide range of practices
  - CMS is increasingly strict
  - RSNs choose EBPs and develop within current funds
- Major limitations applying EBPs / Promising Practices in "real world"- efficacy in studies does not equal effectiveness and efficiency in financial modeling, practice and cultural relevance
- It does not work to simply mandate Best Practices across the board without addressing infrastructure (training, monitoring, rates, and time)
- "Centers of Excellence" generally tied to successful statewide promotion of specific services (ACT, Peer Support)

Benefits Package- Services

Report Recommendations Prioritized by MHD for Further Development

- Do not propose any changes to CMS regarding the structure of the State Plan for Rehabilitative Services
- Prioritize the following 3 EBPs for Statewide Implementation
  - Peer support services provided directly by Consumer and Family Run Organizations
  - Integrated Dual Disorder Treatment for persons with co-occurring mental health and substance use disorders
  - Collaborative Care in Primary Care Settings for populations most effectively served by clinicians located in primary care settings
  - Note- 2 EBPs recommended for children (MTFC & Wraparound) will be considered as part of input process for 1088
- For any EBPs promoted statewide and paid for under Medicaid, conduct a formal actuarial analysis prior to implementation and at the end of each year to determine if RSNs have developed the service

Benefits Package-
Other Report Recommendations

- **Additional recommendations which MHD will continue to study:**
  - Revise current RSN contract requirements for Statewideness and provide definitive guidance to RSNs on implementation
  - Develop encounter coding protocols to allow MHD and RSNs to track the provision of other best practices
  - Develop Centers of Excellence to support the implementation of those best practices prioritized for statewide implementation

Housing Plan Update

Housing Plan
Report Findings

- All RSNs need a range of housing options
  - Licensed residential facilities
  - Community based housing
  - Crisis respite beds
- Permanent Supportive Housing (PSH) most appropriate for most MH consumers
  - All RSNs need additional PSH
  - Estimated need for up to additional 5000 units in WA for people served by the public mental health system
  - Initial goal should be for development of 760 PSH units for mental health consumers between 2007-2010

Housing Plan
Report Findings (cont'd)

- Key elements to successful PSH Implementation
  - Capital financing for new units- approximately 60% of needed dollars are committed and there are sufficient capital investment dollars available within current state and federal allocations if subsidies & direct care and support services are secured
  - Rental subsidies (Section 8 wait lists)- 65% of units can be funded through existing sources leaving a gap of 35% (260 units)
  - Operating subsidies (e.g. landlord incentives, risk mitigation funds)- for excess costs related to renting to mental health consumers based on $1200 per unit per year
  - Access to on site supportive services with low caseload ratios and access to 24/7 response from MH provider

Housing Plan

Report Recommendations Prioritized by MHD for Further Development

- Explore options for funding rent subsidies for 35% of units that can't be funded through existing sources (260 units)
- Explore options for funding operating subsidies (e.g. landlord incentives, risk mitigation funds)- for excess costs of renting to consumers
- Identify whether additional funding for PSH services can be met through current allocations or require any new funds
- Promote the creation of PSH at the RSN and local level by providing best practice information on models, partnerships, and financing and funding TA to build capacity

Housing Plan

Report Recommendations Prioritized by MHD for Further Development (cont'd)

- Ensure PIHP benefit design includes flexible modality for services in home settings with rate sufficient to cover costs
- Suggest standard to identify number of crisis respite beds needed and identify funding if needed
- Develop a closer working relationship with CTED to explore coordinated housing/services projects

Involuntary Treatment Act Study

ITA Study Scope

- MHD contracted with TriWest Group and Advocates for Human Potential to provide analysis and input regarding options related to the mental health Involuntary Treatment Act (ITA) issues.
- The primary findings of the ITA study relate to:
  1. The definition of “grave disability” in Washington’s civil commitment statute;
  2. The definition of “mental disorder” in Washington’s civil commitment statute; and
  3. Washington’s “age of consent” for receiving mental health services, including a review of the law permitting parent-initiated treatment.

Analysis Related to Current Definition of Mental Disorder

Strengths:

- Breadth of definition provides flexibility
- People who meet civil commitment criteria receive services regardless of diagnosis or disorder

Challenges:

- People committed to inpatient psychiatric facilities may not be best served in that setting and may have longer lengths of stay
- Inpatient facilities become providers of last resort when needed services and supports for special populations are not available in the community

Analysis Related to Current Definition of Grave Disability

Strengths:

- Permits civil commitment of people who are experiencing a severe deterioration in functioning without requiring that they become dangerous to themselves or others
- Permits flexibility

Challenges:

- About 62 percent of people detained in FY2006 were considered to be “gravely disabled” (although many may also have met other commitment criteria)

ITA Study

Stakeholder Input

- 74% of Community Forum participants agreed that t*he use of civil commitment too often reflects a lack of sufficient appropriate, recovery-oriented community services*
- Community Forum participants were evenly split over whether the *definition of "mental disorder" in Washington State is too broad*
- *67%* of Community Forum participants disagreed that *the definition of "gravely disabled" in Washington State is too broad*
- Most stakeholders participating in the STI process would support narrowing criteria for civil commitment only if needed community services and supports were in place first.

ITA Study

MHD Recommendations

- MHD is not intending to recommend making any changes to the definition of “mental disorder” or “grave disability” at this time as there is a significant divide among stakeholders on these issues.
- MHD concurs with the majority of stakeholders who expressed that narrowing the criteria for civil commitment should only occur after enhanced community services and resources are in place.

ITA Study

MHD Recommendations (cont'd)

- MHD concurs with the recommendation for additional study related to parent initiated treatment and will do so in the context of the implementation of HB 1088 with an emphasis on assuring appropriate parental involvement.
- MHD concurs with the recommendation for additional study in a number of other areas raised by stakeholders including:
  - Provisions of RCW 10.77 and implementation of the competency to stand trial and "forensic conversion" processes
  - Use of involuntary medications
  - Use of advance directives

Utilization Management Study

UM Study

Report Findings

- Unlike comparison state's managed care entities, RSNs do not directly contract with inpatient providers resulting in fewer tools to manage utilization and expenditures.
- Washington's current policy of holding RSNs accountable for all involuntarily admitted individuals, regardless of Medicaid status, challenges effective RSN UM practices and is a system not found in other comparison states.
- Unlike Washington, a number of comparison states use customized and comprehensive medical necessity criteria as guidelines for accessing inpatient care.
- Like Washington State, comparison states do not have standardized UM procedures at their state hospitals.

UM Study

Report Findings (cont'd)

- There is a lack of consistency and standardization in carrying out UM functions throughout the state
- Data about why some individuals have unusually long stays at state hospitals and why 27% of people discharged are readmitted within one year are not available
- There are barriers to timely state hospital discharges to the community including:
  - Lack of residential placements, housing and services for unfunded consumers.
  - Lack of disincentives for RSNs to have consumers remain in state facilities except when the RSN has exceeded their allotted bed census.
  - Discharge barriers are not being tracked and reported in a systematic way.

UM Study

Report Recommendations Prioritized by MHD for Further Development

- Establish a statewide standardized UM protocol for both acute and extended inpatient admissions and continuing stays.
- Track across the state hospitals uniform data on discharge barriers.
- MHD should consider hiring a Chief Medical Officer versed in public behavioral health UM.
- Study each RSN's hospital diversion and discharge options to forecast needed areas of development.
- Conduct a root cause analysis of why, at times, there are discordant data reports between the MHD and some RSNs.
- Establish a dispute resolution and consumer appeals panel including consumers, RSN and hospital staff at each state hospital

Issues Related to Tribal Governments

Issues Related to Tribal Govts.

MHD recommends issues identified specific to Tribes be further developed and prioritized through the MHD Tribal Mental Health Workgroup

- Develop a handbook to guide RSNs in their interactions with Tribal governments and Tribal providers.
- Develop a clear policy for the involvement of Indian Health Service and 638 facility providers in 1915-B waiver networks including consideration of direct contracting with Tribes.
- Convene a work group to develop recommendations on how to incorporate Tribal traditional healing practices within the public mental health benefit.
- Incorporate specific provisions for the inclusion of Tribes in any systematic efforts to promote best practices.
- Continue facilitation of statewide forums such as the Tribal Mental Health Work Group and ensure the participation of senior staff in these forums.

Issues Related to Tribal Govts. (cont'd)

- Explore options for allowing Tribes to detain individuals independent of RSN approval by giving Tribes and Tribal Courts the ability to appoint Tribal DMHPs
- Explore options for requiring RSNs to accept referrals for 72-hour detentions from Tribes, rather than "wasting resources" by engaging a DMHP to conduct an additional assessment.
- Explore options for increasing the resources available to Tribal governments for housing and services for mental health services clients including access to support services and landlord risk mitigation funds.
- Increase the coordination and collaboration related to housing between Tribal governments and local and state government.
- Explore request of Tribes for access to voluntary beds without having to go through RSN inpatient authorization processes.